

Plan of Service Development and Review Manual

The following guidance should be used during the development, submission and approval of all plans of service for the Community Options (CO) Waiver, Community First Choice (CFC), Increased Community Services (ICS), and Medical Assistance Personal Care (MAPC) programs.

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Program Information

The Community Options Waiver, Community First Choice, Increased Community Services, and Medical Assistance Personal Care programs each target participants in need of support of activities of daily living. Certain requirements apply to each program; however, they each use the same Plan of Service to outline services. This Plan of Service should capture all services that will be provided to the participant (under these programs or through other Medicaid or non-Medicaid programs).

Note that when submitting a Plan of Service, only services allowable under these programs are being approved. Other services/items offered under other programs (e.g., durable medical equipment, skilled nursing) must be approved by those divisions.

All of these programs are operated by the Department of Health and Mental Hygiene's Medical Assistance Program. Two divisions are responsible for the oversight of the program: Community Options Administrative Division and the Division of Evaluation and Service Review.

Community Options (CO) Waiver participants must meet a nursing facility level of care as determined by the Department based on its standardized assessment. In addition, these participants must meet certain financial eligibility and complete an annual application. Participants in the waiver must be 18 years or above... This waiver has reached its enrollment cap. Only individuals invited to apply from the waiver registry or who have Medicaid Long-Term Care and are living in an institution are eligible to apply for this program. Community residents may not apply directly to this program without the registry invitation.

Increased Community Service (ICS) participants must meet all of the requirements of the Community Options Waiver and may also receive all of the service offered under that program. However, the application for enrolling in these services has different financial requirements than the CO waiver. Only institutional residents who have applied for the CO waiver and been denied due to over scale income, may apply to ICS. Institutional residents must have a CO denial letter prior to applying to ICS. This program is limited to 30 participants.

Community First Choice (CFC) participants must meet an institutional level of care, which includes nursing facility level of care. Participants may be of any age and must reside in a community setting not including an assisted living facility, group home, or alternative living unit.

Medical Assistance Personal Care (MAPC) program participants do not meet the nursing facility level of care standard, however do have needs related to activities of daily living and meet the MAPC level of care. In addition to other State Plan services, participants in the MAPC program may only receive personal assistance, supports planning and nurse monitoring. Participants may be of any age but must reside in the community.

Developing a Plan of Service

Services Being Provided in Other Programs

The supports planner should identify all other Medicaid programs in which the person is receiving services. These programs may include:

- Brain Injury Waiver
- Community Pathways Waiver
- Medical Day Care Waiver
- Rare and Expensive Case Management Program (REM)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) which offers additional Medicaid benefits to anyone on Medicaid or MCHP who is under 21 years of age.
- Other Medicaid programs

Enrollment in other waiver programs and REM are indicated in the client profile in the Eligibility section of the LTSSMaryland system. On the left navigation bar, select Client Summary, then Eligibility Information. Data under the Special Program Code section indicates current or prior enrollment in a waiver program, hospice, or REM. Supports planners should review the eligibility to determine if other programs are available and work with the applicant/participant and any other case manager/service coordinator assigned.

Any Plan of Service related to these programs should be included as an upload to the LTSSMaryland system prior to submission of a Plan of Service for any program (CO, ICS, CFC and MAPC). This will help provide supporting documentation for the need of each service and avoid duplication of services which may cause non-payment or take back.

Functional Needs

Plans of service should be developed in association with the need for support in activities of daily living (ADLs) and instrumental activities of daily living (IADLs). When describing the service being requested, citing the ADL or IADS need will assist the reviewer when approving a Plan of Service.

Activities of Daily Living (ADLs)

- Bathing/completing personal hygiene routines
- Dressing/changing clothes
- Eating
- Mobility
 - Transferring from a bed, chair, or other structure
 - Moving, turning, and positioning the body while in bed or in a wheelchair
 - Moving about indoors or outdoors
- Toileting
 - Bladder/bowel requirements
 - Routines associated with the achievement or maintenance of continence
 - Incontinence care

Instrumental Activities of Daily Living (IADLs)

- Preparing meals
- Performing light chores that are incidental to the personal assistance services provided to the participant
- Shopping for groceries
- Nutritional planning
- Traveling as needed
- Managing finances/handling money
- Using the telephone or other appropriate means of communication
- Reading
- Planning and making decisions

Plan of Service

There are nine (9) sections in the LTSSMaryland system to be completed and reviewed prior to submission of a Plan of Service. These sections include:

- Overview Information
- Strengths
- Goals
- Risks
- Self-Direction
- Emergency Backup Plans
- Services
- Signatures
- Review

All sections must be completed prior to submission to the Department. There are two levels of submission at the Supports Planning Agency level: supports planner to team lead/supervisor and team lead/supervisor to DHMH. At either of these steps, a clarification request may be sent to acquire additional information or clarify a request for services.

Overview Information

This section is largely populated by the client profile demographic information and will pull all of the information noted as “primary” such as phone number and address.

Program Type

By selecting a program type on the Plan of Service, a different set of allowable services will be listed based on program limitations. For instance, participants in the CO waiver will have access to all services while participants only enrolled in MAPC will only have access to personal assistance, nurse monitoring and supports planning.

It is critical that the correct program type be selected for the plan of service to avoid delays in the enrollment process. Supports planners must read the eligibility and LOC information in the LTSS before doing a POS to determine which plan type to enter.

For New Applicants

In the Client Summary, Expand All to view all eligibility information. If there is an active waiver application, the program of application will be listed under Program Snapshot and the POS type should match the waiver application, either CO or ICS.

If there is no waiver application pending, then the person is either a CFC or MAPC applicant.

Both CFC and MAPC applicants must have a qualifying Coverage Group. Please see Appendix A for Coverage Group details.

If the person has a qualifying coverage group, the program type will be determined by the Level of Care (LOC). If the person meets an institutional level of care, this will be indicated by either of the following; a

special program code indicating participation in another waiver program (see Appendix B) or a nursing facility LOC.

Please note that REM is not a waiver and the REM special program codes do not indicate an institutional level of care.

If a person is participating in another waiver program or meets NF LOC, then they are eligible for CFC. If they do not meet this criterion, then they may still be eligible for MAPC.

In order to be eligible for MAPC, the MAPC LOC must be Yes in the Level of Care section of the Client Summary Page.

For Enrolled Participants

The program of enrollment will be indicated in the Program Snapshot section of the Client Summary. However, the eligibility information above should be reviewed to ensure correct enrollment and determine any change in eligibility status at the annual redetermination.

Please see the spreadsheet below for a list of all services offered and the programs that offer them:

	MAPC	CFC	CO Waiver and ICS Program *
Personal Assistance Services	X	X	
Case Management/Supports Planning	X	X	
Nurse Monitoring	X	X	
Home Delivered Meals		X	
Environmental Assessments		X	
Environmental Adaptations		X	
Technology		X	
Personal Emergency Response Systems		X	
Consumer Training		X	
Transition Services		X	
Family Training			X
Nutritionist/Dietician			X
Assisted Living			X
Medical Day Care **			X
Behavioral Consultation **			X
Senior Center Plus **			X

* All CO waiver and ICS program participants are eligible for CFC services.

** These services are allowable in an Assisted Living Facility. All other services are not.

Plan of Service Type

Pending Applicants

There is a two-step process for completing and approving plans of service for pending applicants for all programs (CO, ICS, CFC and MAPC):

- Completing and submitting a provisional Plan of Service which includes services but may not list all providers.
- Updating the provisional Plan of Service to complete an initial Plan of Service.

A provisional Plan of Service is normally developed while a person is planning to leave an institution and not all information is known prior to discharge – specifically certain provider information. The Department may approve a provisional Plan of Service if all other requirements are met.

At a minimum, the following signatures are required by the Department when approving a provisional Plan of Service:

- Participant
- Supports Planner
- Personal Assistance provider(s), if known
- LHD Nurse Monitor

Once this provider information is known, the supports planner must convert the Plan of Service by editing the approved provisional Plan of Service and changing the Plan of Service type. An initial Plan of Service is completed when services are ready to begin and all information required in the Plan of Service is known. Initial plans of service are completed for new community participants, registry applicants and when a person leaves an institution.

Enrolled Participants

An annual Plan of Service must be completed at redetermination for all programs (CO, ICS, CFC and MAPC).

At a minimum, the following signatures are required by the Department when approving an initial or annual Plan of Service:

- Participant
- Supports Planner
- Personal Assistance provider(s)
- LHD Nurse Monitor

Please note the following:

- While not required at the time of approval, it is highly recommended that the signature of the emergency backup provider and any agency-based nurse supervisor are included in the Plan of Service.

- If signature of personal assistance provider has not yet been collected, please include a comment in the Review Section that contact and agreement has been made with the personal assistant provider to provide the service on the effective date of the Plan of Service.
 - However, signature must be gathered as soon as possible.
- If nurse monitoring will be conducted by the Local Health Department, a signature will be required to ensure readiness at the time of the effective date.
- Signatures for State Plan services are not required.

All previously approved plans of service may be “revised” for future planned changes. This allows a certain amount of information to be pre-populated and edited which ensures consistency over time. Revisions are required when services or providers change or when a participant has a significant social or health change.

- Annual and initial will be matched against the flexible budget.
- Revised plans of service should include all services to be provided throughout the duration of the Plan of Service (from effective date through 52 weeks).
 - If a one-time or short-term service has been approved on a POS, however a POS modification was necessary before it was provided (e.g., technology was approved but not purchased yet), that service should remain on the Plan of Service until completed.
 - If a one-time or short-term service has been approved on a POS and has been provided, the supports planner should remove it from the POS when submitting a revision or annual POS.
 - Revisions for current enrolled participants do not have to meet the initial flexible budget standard during the first year of transition (ending calendar year 2014).

Plan of Service Effective Date

Enter the proposed date that the Plan of Service is requested to be effective. When adding this date, ensure that there is enough time for the POS to be reviewed, clarification received, and then approved.

The following is recommended when requesting a date:

- For an annual POS, effective date should be set at the medical/technical redetermination date.
- For an initial POS, set the effective date for date of discharge (if known, if not please estimate).
- For a revised POS, effective date should be set at the time services should take effect.
- The Department will only approve a Plan of Service retroactively under certain circumstances. It is the discretion of the Department to approve a Plan of Service retroactively.

A service should be not provided until it is listed on an approved Plan of Service and the participant has an active eligibility span to be in the program.

It is the supports planner’s responsibility to ensure that the POS is up to date and submitted timely. Any gaps in plans of service based on the SPA failure to submit timely will force a Corrective Action Plan and recoupment of funds. A support planner must not initiate services for a participant until after the Plan of Service has been approved by the Department and the participant is actively enrolled.

An urgent request for a Plan of Service approval may be submitted to the Department; however, the Department cannot guarantee a specific timeframe. After submission, a subsequent email to the POS Unit Staff noting the client ID# and a message of the reason for the emergency should be sent.

Please allow at least 2 weeks for POS approval. When POS Unit is flooded with “urgent” plans, normal processing times are delayed. These delays are sometimes caused by requests that are only urgent because of delays at the supports planner level. Lack of planning is not an emergency. The urgent requests sent in to the POS Unit mailbox should reflect truly urgent situations.

Examples of urgent revisions which SHOULD be sent to the POS box include:

- A change in provider based on a Reportable Event (provider quit, was fired, was negligent, etc.)
- Involuntary discharge from an institution
- Hospital discharge

Examples that SHOULD NOT be sent to the POS box as urgent:

- Routine nursing facility discharges
- Checking the status on a previously submitted plan
- Plans not submitted timely

Please submit plans at least 2 weeks in advance of the requested effective date and communicate to the participant time frames for approval prior to service changes being implemented.

DO NOT instruct providers to call or email the POS Unit to check on the status of a plan. The Department is not authorized to release any participant information to a provider and is unable to update them. It is the supports planner’s responsibility to monitor the status and communicate with others.

Strengths

The purpose of this section is for the supports planner and participant to identify strengths. Each supports planning agency will have a different way of working with participants to ensure services are self-directed and are meeting the needs of the participant.

Strengths should be unique and individualized for the participant. Supports planning agencies should not have prescribed or predetermined strengths for participants. Strengths should consider the entire person and their life outside of the Medicaid system. Areas to explore and consider with participants while identifying strengths include the following:

- Friendships
- Faith Communities
- Addictions or Recovery communities
- Employment
- Hobbies
- Arts and Talents
- Education

– Family Relationships

Examples of strengths include maintaining sobriety, mentoring youth, staying out of the hospital, being a good friend/singer/artist/parent, etc.

Again, strengths should be individualized and discovered through the person-centered planning process. Representatives and other supporters may help identify strengths and should be included in person-centered planning.

No standardized, non-specific strengths should be placed on plans. A single, unique strength related to the person is required but there is no limit on the number that may be included on the plan.

Goals

The Department is collecting information on outcomes of our participants. This section should include any short term and long term goals that the participant would like to achieve. After submitting a Plan of Service, these goals can be managed in the client profile so they can be kept up to date. Goals will pre-populate from the POS to the client profile; and vice versa when creating a revised or annual POS.

Each supports planner and participant should select a goal category they feel best fits the desired outcome. The following options are available when selecting a goal category:

- Education
- Family/Personal Life
- Social/Recreational
- Health
- Employment
- Housing
- Other

When a goal has been achieved or discontinued it will no longer populate on the Plan of Service.

Risks

There are two ways risks will become part of a Plan of Service: through the interRAI-Home Care assessment or through discussions with the participant and their representatives. These may be cited under each service requested, in the description section, as a rationale for why the service request (e.g., item, frequency, duration, etc.) is necessary.

The interRAI-Home Care assessment automatically reviews parts of the assessment and identifies areas that may require additional follow-up or planning. These are called Clinical Assessment Protocols (CAPs) and are pre-populated on the Plan of Service (from the most recent interRAI-Home Care assessment). Each CAP can be used to help interpret some of the information that has been collected through the interRAI.

- Note that any risks that the participant disagrees with may be deleted from the Plan of Service.
- Each CAP that is triggered has a brief description on the Plan of Service.

- Additional information for each CAP is available under the Assessment Results page
 - Click the link for each CAP and a printable description of the problem, goals of service, and approach to working with a participant with the issue identified.

Any additional risks may be added, or deleted, as necessary.

Self-Direction

There are many levels of self-direction and the extent to which a participant “self-directs” varies. The Department collects information on how many participants have an active role in designing their service package as well as whether they are involved in the recruitment and employment responsibilities of their personal assistant provider. Each participant has the option to flexibly change the rate of their provider receives for independent personal assistance, with the providers consent. This can be done to hire more experienced workers or to offer raises throughout the year.

- Note that only when the “setting payment rate” check box is set to “yes” will the participant and/or supports planner be able to change the rate of the independent personal assistant.

Additionally, a Self-Direction Training Program, offered through the Maryland Department of Disabilities (MDOD), is available to any participant interested in self-directing a portion or all of their services (applying or enrolled in CO, ICS, CFC and MAPC). The program provides training on how to recruit, hire, select, dismiss, supervise and manage personal assistance providers, as well as information on general health and safety, emergency preparedness and available state and national resources. The training program will also focus on enhancing skills necessary for self direction such as time and money management, communication skills, listening skills, boundaries, assertiveness, self advocacy, organization, responsibility, administrative skills, giving clear direction and flexibility.

Trainings will be offered in small and large group settings, through web-based self-paced training modules and in individualized one on one training sessions. The Self-Direction Training Program is optional and does not require a person to self-direct after taking the training. If a participant is interested in self direction training, a referral can be made through the LTSSMaryland system and MDOD will contact the person directly within two business days.

Emergency Backup Plans

Each participant must have access to an alternate provider(s) in case of an emergency. At least one backup provider is required. Accurate contact information is vital.

- If an agency is the sole provider of personal assistance, they may also be the primary backup.
- Additional backups are recommended in case of long term emergency needs.
- A Plan of Service modification is not required when a backup is used; only if the change is long term (greater than one week).
- Family members may be listed as the emergency backup (primary or alternate).
- Backups may be enrolled Medicaid providers.

- If so, they must bill for services using the ISAS call-in system. All Medicaid personal assistance providers should be aware of ISAS protocol when calling in.
- An independent personal assistance provider may not bill more than 40 hours per week of services, regardless of emergency.
- Personal assistance may not be billed for 24 hours of consecutive service and the provider must clock-in and clock-out when services are not being provided (e.g., sleeping overnight).
- A Plan of Service will not be approved without at least one primary backup listed.
- The primary backup's signature must be on the Plan of Service.

Alternate personal assistance providers who do not have regularly scheduled hours of service with a participant may be placed in the emergency back-up section so that they may bill through ISAS, if and when called upon by the participant to provide services. Any enrolled provider who may provide personal assistance services to a participant must be listed on the approved plan of service in order to bill through ISAS.

Services

This section is meant to collect a list of all services necessary to meet the needs of the participant. Note that only certain service types are available under the Medicaid programs and there may be limitations on these services per State and federal regulations. Please see each service below for general guidance and recommendations when selecting services.

All plans of service should be developed based on a full year of service, regardless of when redetermination dates are set.

- For example, if a Plan of Service will be effective February 1, all services should be planned from February 1 through January 31 of the following year (52 weeks).
- No service should be provided prior to both the approval of the Plan of Service and the participant's effective date of program eligibility.
 - Providers are at risk of non-payment if the Plan of Service is not approved or eligibility is not attained at the time services were delivered.
- Cost neutrality for waiver participants is based on an annualized cost to the program and plans of service must be sustainable long term.
- Developing a Plan of Service for a shorter term based on the redetermination date negates the Department's ability to analyze whether a Plan of Service is cost effective over time. Short term services should show limited frequency. For instance, a temporary increase in personal assistance should be requested as:
 - 60 hours of personal assistance for 8 weeks;
 - 40 hours of personal assistance for 44 weeks
 - In the comments section for the service, write the approximate start/end date for the duration of the increase and revise the plan if necessary.
- Retrospective changes or other shorter term changes should not be submitted as Plan of Service modifications.

- It is the responsibility of the supports planner to monitor usage of services (specifically personal assistance) to ensure the approved service levels are met.
- Urgent requests for services that require immediate purchase or approval must be submitted as a revised Plan of Service with the appropriate adjustments made. Once submitted, please e-mail the POS Unit at dhmh.posunit@maryland.gov (and the assigned POS Unit staff if known) with the subject reading “Urgent POS Review Request.”
 - Only submit an urgent request for plans of service which need approval within two business days.
 - The Department cannot guarantee an immediate response however this will expedite the process.
 - Please see the POS Effective Date section on pages 10-11 of this manual for clarification of urgent versus non-urgent requests.

Any description/rationale dates or duration associated with services can be indicated in the comments section within each service line. Plans of service are reviewed for annual sustainability and effectiveness.

Also ensure that any functional needs of the participant are connected to the service being provided. All services should correspond to a functional need (ADL, IADL, or other diagnosis or condition) that is noted in the interRAI assessment or by a physician.

Note that all services listed under the State Plan service are approved and denied by other programs outside of the Department’s Plan of Service Unit. The approval of a Plan of Service does not override the decision of the program responsible for providing that service.

* Note that all descriptions outlined in this manual are superseded by the Code of Maryland Regulations (COMAR).

Frequency Options

Each individual service has associated Frequency Types available for the input of service data. For example, service frequency types include Daily, Weekly, Monthly and Annual. The selection of a specific Frequency Type will drive the additional fields within the section as well as the maximum values allowable for each field. For example, if nurse monitoring was selected weekly, the user must specify the following: Days per week (max value is 7), How many weeks (max value is 52) and Rate (pre-populated based on current Medicaid rate). By inputting each individual component the LTSSMaryland system will calculate the Annual Cost field for that service.

Another unique feature related to Frequency Type for specific services is the ability to use the Daily Chart. When available, by clicking the checkbox for Use Daily Chart as seen in the figure below, the user will be able to enter the number of hours and minutes they plan to provide for each specific day in the week and LTSSMaryland will calculate the Hours per week for that service by taking the sum of all the hours for each individual day in the Daily Chart. Once again, there will be default and maximum values

allowable based on the Frequency Type selected for the service.

Plan of Service — Services

Manage

Back to Summary

Next Section

Manage Services

Service Information

POS Service: *

Personal Assistance Agency — Hourly

Service Type:

Waiver Service

Frequency Type

☒ Daily
 ☐ Weekly
 ☐ Monthly
 ☐ Annual

Daily chart can be used to help calculate weekly hours.

☒ Use Daily Chart?

Sunday:

0

Monday:

0

Tuesday:

0

Wednesday:

0

Thursday:

0

Friday:

0

Saturday:

0

Hours per week:

0

(max value is 84)

How many weeks:

0

(max value is 52)

Rate (\$):

3.12

(max value is \$3.12)

Annual Cost (\$):

0.00

Provider Information

Provider Name: *

Search

Reason for Service/Details:

Add Service

Saved Services

POS Service	Service Type	Provider Name	Units	Frequency	Rate (\$)	Annual (\$)	Actions
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POS Costs

Annual Waiver Plan Services Total:

\$0.00

Annual State Plan Services Total:

\$0.00

Annual CFC Services Total:

\$0.00

Total POS Cost:

\$0.00

Annual Non-Medicaid Service Total:

\$0.00

(POS total costs does not include Annual Non-Medicaid Services)

5.5.14 Version

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Flexible Budget

Each participant is given a recommended flexible budget based on the needs identified through the interRAI-Home Care assessment. The purpose of this process is to ensure that all participants are given an equitable allocation of services based on what is known about their ADL and IADL needs.

This assessment is completed prior to the development of the Plan of Service and generates a Resource Utilization Group (RUG) score. This RUG score is used to assign a recommended flexible budget based on need. The interRAI-HC uses statistically validated algorithms to assign clients to 1 of 23 resource utilization groups (RUGs). DHMH has assigned each RUG to one of seven groups and has developed a budget for each group based on a scale of needs. The table below describes the budget for each group.

RUGs-Based Flexible Budget

Group	RUG	RUG Description	Budget
1	PA1	Physical Function – Low ADL	\$8,336
	BA1	Behavioral – Low ADL	\$8,336
	CA1	Clinical Complex – Low ADL	\$8,336
	IA1	Cognitive Impairment – Low ADL	\$8,336
	PA2	Physical Function – Low ADL, Low to High IADL	\$8,336
	RA1	Rehabilitation – Low ADL	\$8,336
2	BA2	Behavioral – Low ADL, High IADL	\$16,167
	CA2	Clinical Complex – Low ADL, High IADL	\$16,167
	IA2	Cognitive Impairment – Low ADL, Low to High IADL	\$16,167
	PB0	Physical Function – Low to Medium ADL	\$16,167
3	CB0	Clinical Complex – Low to Medium ADL	\$22,504
	RA2	Rehabilitation Low – Low ADL, High IADL	\$22,504
	PC0	Physical Function – Medium to High ADL	\$22,504
	SSA	Special Care – Low to High ADL	\$22,504
	IB0	Cognitive Impairment – Medium ADL	\$22,504
	BB0	Behavioral – Medium ADL	\$22,504
4	PD0	Physical Function – High ADL	\$30,314
	CC0	Clinical Complex – High ADL	\$30,314
5	SE1	Extensive Services 1 – Medium to High ADL	\$34,545
	RB0	Rehabilitation High – High ADL	\$34,545
	SSB	Special Care – Very High ADL	\$34,545
6	SE2	Extensive Services 2 – Medium to High ADL	\$43,558
7	SE3	Extensive Services 3 – Medium to High ADL	\$76,360

This recommended flexible budget is designed to give participants with similar needs a starting point for requesting the following services:

- Personal Assistance
- Home-Delivered Meals
- *Other* Items that Substitute for Human Assistance

Only the above services are included in the flexible budget. All other services should be completed based on guidance within this document. The cost of other services is calculated separately.

Any Plan of Service submitted above the flexible budget must include an exceptions form with an explanation and any additional documentation for the need for services above the flexible budget. This will apply to all annual, initial and significant change plans of service during transition into Community First Choice.

The exceptions form should be uploaded to the LTSSMaryland client attachment section for the appropriate participant.

Gather documentation to support the exception. Former level of service alone is not sufficient to justify additional hours of personal assistance. If there is no supporting documentation available or obtainable, note that in the overview so that the reviewer knows that there will not be any supporting documents obtained and why.

Plans of service with an exception form will be referred to clinical staff at the Department for further review. Please see the section on Plan of Service Review at the end of this manual.

Personal Assistance

Personal assistance services are offered under the CFC and MAPC programs. CO waiver and ICS participants are eligible for CFC personal assistance services if they are not residing in an assisted living facility. The Department will review hours requested based on the recommended budget, the medical and social needs identified in the interRAI-Home Care assessment and recommendations from the Local Health Department.

The number of hours requested should correspond to functional needs (ADL, IADL, or other diagnosis or condition) that are noted in the interRAI assessment or by a physician.

Please see the spreadsheet below of Projected Personal Assistance Hours for each budget. This may help in comparing requested plans of service with what the budget has projected.

Projected Personal Assistance Hours For Each Group

		Independent Provider (at standard rate)		Agency Provider	
		Approximate hours per day (7-day per week schedule)	Approximate hours per day (5-day per week schedule)	Approximate hours per day (7-day per week schedule)	Approximate hours per day (5-day per week schedule)
Group 1	\$8,336	2	2.5	1.5	2
Group 2	\$16,167	3.5	5	3	4
Group 3	\$22,504	5	7	4	6
Group 4	\$30,314	7	9.5	5	8
Group 5	\$34,545	8	11	6	9
Group 6	\$43,558	10	14	7.5	11
Group 7	\$76,360	17	23	13	20

Personal Assistance Hours Breakdown

For plans of service that are under or meet the flexible budget, the Department recommends submitting a request with the total number of hours per week for each provider. This ensures flexibility for all providers on the plan.

If the plan is above the flexible budget, the Department recommends submitting daily hours. Furthermore, a staffing pattern of activities performed during that timeframe may be included to support the number of hours. Please include a reference to any coordinated care (formal, informal) that may be occurring in conjunction with personal assistance.

Duration of a Plan of Service

All plans of service should be developed based on a full year of service, regardless of when redetermination dates are set.

- For example, if a Plan of Service will be effective February 1, all services should be planned from February 1 through January 31 of the following year (52 weeks).
 - An item or service should remain on the Plan of Service until it is purchased or completed. Once it has been provided, then it may be removed from the Plan of Service. This ensures that the date of service falls within an approved Plan of Service and all billing/claims should be processed accordingly.
- No service should be provided prior to both the approval of the Plan of Service and the effective date of program eligibility.
 - Providers are at risk of non-payment if the Plan of Service is not approved or eligibility is not attained on the date services were delivered.
- Cost neutrality for waiver participants is based on an annualized cost to the program and must be sustainable long term.
- Developing a Plan of Service for a shorter term based on the redetermination date negates the Department's ability to analyze whether a Plan of Service is cost effective over time. Short term

services should show limited frequency. For instance, a temporary increase in personal assistance should be shown as:

- 60 hours of personal assistance for 8 weeks;
- 40 hours of personal assistance for 44 weeks.

Previously approved hours, retrospective changes or other shorter term changes should not be submitted as Plan of Service modifications. It is the responsibility of the supports planner to monitor usage of services (specifically personal assistance) to ensure the approved service levels are met.

- Only a long term (greater than one week in duration and expected to continue) change should prompt a revised Plan of Service to request additional services.
- Temporary emergency situations (e.g., weather, temporary loss of provider) do not require a Plan of Service modification.
- Agency and independent provider respite hours have been converted to personal assistance hours and all previous agency or independent providers of respite will bill as personal assistance providers.
 - Unless hours for this provider are planned, a personal assistance provider will not need to have hours on the Plan of Service - they will simply fill the hours not completed by the other workers.
 - If no planned hours are assigned to the personal assistant, the provider should be listed in the emergency back-up section.
 - If hours are scheduled for the personal assistant, they should be noted as personal assistance hours on in the services section.

Payment for Personal Assistance

All personal assistance providers, both independent and agency, must be enrolled in the In-Home Supports Assurance System (ISAS). This is an automated time-keeping system that tracks clock-in and clock-out time of providers.

- The ISAS billing system will pay based on hours worked within program limitations for independent personal assistance providers.
 - An independent personal assistance provider may not exceed 40 hours per week of services. Therefore, the Plan of Service may not contain hours exceeding 40 for an independent provider.
 - Emergency backup providers enrolled in Medicaid must also use the ISAS system in order to be paid.
- Supports planners should ensure that each Medicaid provider enroll in the ISAS system prior to the effective date of a Plan of Service. If a provider is not enrolled in ISAS, the provider will not be paid.
- Personal assistance providers may not have multiple rates on the same Plan of Service; providers will not be paid unless one rate is on the Plan of Service.
- Personal assistance providers should only be on the Plan of Service more than once if there is a planned frequency change during the following 52 weeks.

All independent personal assistance providers must be enrolled with the Department's fiscal intermediary, Public Partnerships, LLC (PPL). PPL is responsible for payments to providers. Without completing the required paperwork, the provider will not receive payment for services.

Additional Requirements

- Personal assistance may not be billed for 24 hours of consecutive service and the provider must clock-in and clock-out when services are not being provided (e.g., sleeping overnight).
- When self-directing, each provider may agree on a different rate. The current rates must be in the Plan of Service to allow ISAS to accurately bill for the service.
- A change in rate for independent personal assistance providers requires a Plan of Service modification.
- Personal assistance does not include any activities performed without the participant present such as running errands or grocery shopping without the participant.
- Independent personal assistance providers are limited to 40 hours per week, per participant. A single independent provider may not be on the plan of service for greater than 40 hours per week. The week coincides with the pay cycle from Friday through Thursday each week. Independent providers cannot be paid for more than 40 hours each Friday through Thursday.
- The LHD is responsible for monitoring the quality of personal assistance services. This means that they may request documents, schedule joint home visits, and inspect the quality of care. Enrolled personal assistance provider agencies must respond to LHD requests.

Shared Personal Assistance

Shared personal assistance may be utilized when two participants are living together and choose to have the same independent personal assistance provider. This personal assistance provider will be paid 2/3 the rate for each person (i.e., if the standard rate for one person is \$12.27, then the provider will be paid \$8.32 for each person served, or \$16.64 per hour). This service allows a provider to clock-in and clock out just once with ISAS when serving two people in the same residence.

Each participant must have the same provider on their Plan of Service listed as a shared personal assistant provider. The duration and frequency must match on each Plan of Service.

Each participant should also have the provider listed on the plans of service as an individual personal assistance provider. If all planned hours are shared, the individual personal assistance may be reflected on the emergency back-up section.

For example, if John and Mary are sharing personal assistance for 40 hours per week, both John and Mary must have the shared provider on their POS for 40 hours per week.

If John receives additional hours per week that are not shared, then those hours must be listed separately on the plan.

If the shared provider takes Mary to the doctor once per month and John stays at home, then Mary must have individual personal assistance on her POS so that the provider can bill for the individual service when the participants are not together.

The shared rate can only be billed when both participants are present.

Home-Delivered Meals

Home –delivered meals are a covered service under CFC as an item that substitutes for human assistance and are not intended to supplement a participant’s grocery budget. Each meal is delivered to the participant's home, which includes the cost of the food, food preparation, and delivery. This service may not constitute the participant's full nutritional regimen of three meals per day and cannot replace the purchase of groceries.

A home-delivered meal should not overlap with personal assistance. Personal assistance services include assistance with IADLS, which by definition include meal preparation.

- The supports planner and participant should take into consideration meals that may require additional preparation beyond the ability of the participant (such as the use of an oven/microwave). While these types of meals may be appropriate for certain participants, others may require alternative cold meals.
- Participants with limited mobility may utilize items that substitute for human assistance (technology or adaptations) to ensure delivery of meals.
 - Items such as lockboxes so a provider may access a key to enter, keypads for a door lock, or intercom with automatic door locks may be covered based on the needs of the participant.

10.09.84.02.B (18) “Instrumental activities of daily living (IADLs)” means tasks or activities that include, but are not limited to: (a) Preparing meals; “

However, meal preparation is already covered by the cost of the service. As such, an individual should only have one of these services at any given time. In some circumstances, these may both occur in the same day. For instance, if the personal assistant works from 8am – 10am, a home delivered meal may be needed for lunch and/or dinner, when no personal assistance provider is available.

Additional guidance:

- Home-delivered meals may not exceed 2 meals per day, 7 days per week.
- Multiple providers may exist for this service.
- Each meal is intended for consumption at home.

This service is not available to MAPC participants or CO/ICS waiver participants who are not eligible for CFC, i.e. are assisted living residents.

Other Items that Substitute for Human Assistance

There are no specific requirements for this service except that it will take the place of a personal assistance worker and any potential hours they would have served. Certain items that substitute for human assistance have been pre-authorized by CMS and are included in their own service categories for the purpose of the Plan of Service. These items are home-delivered meals, environmental assessments, environmental adaptations, and technology. This category of “other items that substitute for human assistance” should include only items that are not covered under those other categories.

Potential items that substitute for human assistance, that are not covered under another service definition, will be considered on a case-by-case basis in conjunction with the full Plan of Service. Potential items that substitute for human assistance are service animal, delivery services, or other non-medical in-home services.

Other items that substitute for human assistance *do not* include items that were determined not medically necessary under another coverage category. For example, it does not include durable medical equipment determined not necessary by the DME program.

Items may not be for recreational items such as televisions, gaming systems, DVD players, cable television access, or other luxury items outside of the basic essentials.

These services are not available to MAPC participants.

Community First Choice Services

Personal Assistance

See flexible budget section.

Home-Delivered Meals

See flexible budget section.

Consumer Training

This service is a Community First Choice service and is different from the Maryland Department of Disabilities (MDOD) self-direction training. MDOD training on self-direction of personal assistance services is an administrative function of the program and is not listed in the services section on the POS.

Consumer training is designed to offer training to the participant on the acquisition, maintenance and enhancement of skills necessary to perform ADLs, IADLs, and Health Related Tasks. The topics covered by consumer training may include, but are not limited to:

- Money management and budgeting,
- Independent living, and
- Meal planning.

These activities are to be targeted to the individualized needs of the participant receiving the training; and sensitive of the educational background, culture, and general environment of the participant receiving the training. Consumer training will be provided by an approved Medicaid provider.

Items that Substitute for Human Assistance

Services offered under items that substitute for human assistance replace those otherwise offered under personal assistance. The following list of services is covered under the authority of items that substitute for human assistance, but will be entered on the Plan of Service in distinct categories. Environmental assessments, environmental adaptations, and technology should be entered under their own categories on the POS and not placed under “Other” items that substitute for human assistance.

Recreational items such as televisions, gaming systems, DVD players, cable television access, or other luxury items outside of the basic essentials are not covered.

These services are not available to MAPC participants.

Environmental Assessment

An assessment of the person's home may be completed upon request to identify improvements to make the house functional and safe for the participant. This service is not covered under the MAPC program.

The assessment may be necessary to:

- Ensure the health and safety of a participant with special environmental needs; and
- Obtain additional professional advice from an occupational therapist about the:
 - Physical structure of a participant's home or residence; and
 - Functional or mental limitations or disabilities of a participant as they relate to the environment.

Included in the environmental assessment, as necessary, may be:

- An evaluation of the presence and likely progression of a disability or a chronic illness or condition in a participant;
- Environmental factors in the facility or home;
- The participant's ability to perform activities of daily living;
- The participant's strength, range of motion, and endurance; and
- The participant's need for assistive devices and equipment.

Recommendations and findings should be uploaded to the client attachment portion of the LTSSMaryland system. Additionally, pictures should be uploaded to further support the recommendations.

This service may not be provided prior to the effective date of the participant's eligibility for services.

Environmental Adaptations

Prior to submitting a request for an environmental adaptation, an environmental assessment should be performed by an Occupational Therapist. Multiple quotes/bids are required for any purchase exceeding \$1,000. There is a combined limit for this service of \$15,000 over three years when combined with technology. This service is not covered under the MAPC program. There are no limitations on the number of homes in which adaptations may be billed during this timeframe.

If the adaptation is for a rental property, the request must be accompanied by a signed letter from the landlord that states that the adaptation is allowed in the residence and the participant may live there for at least one year.

Adaptations should be itemized with a description and should include, when applicable, the model number, item number and manufacturer as well as any size or measurements that may be pertinent. Documentation should be uploaded to the client attachment portion of the LTSSMaryland system.

These items may include:

- Automatic door openers
- Grab bars
- Ramp
- Repair to previous adaptation
- Stair glide or lift
- Structural change (internal)
- Structural change (external)
- Other

Adaptations may not include adaptations that:

- Are of general maintenance, such as carpeting, roof repair, and central air conditioning;
- Are not of direct medical or remedial benefit to the participant;
- Add to the home's total square footage; or
- Modify the exterior of the home, other than the provision of ramps.

Technology

Technology includes non-experimental technology or adaptive equipment, excluding service animals, which enables a participant to live in the community and to participate in community activities. This service is not covered under the MAPC program.

Many items that are medically necessary and require a physician's order, otherwise considered technology, may be covered under Medicaid's DMS/DME program. Items not listed under the DMS/DME formulary may be covered under the CFC program if it substitutes for human assistance and is supported by 10.09.84.18. However, items that have been determined not medically necessary by the DMS/DME program are not allowable as technology. Additionally, any repair to an item covered under DMS/DME must be submitted to that program (whether purchased by the Department or another program). Repairs to items covered under Technology (whether purchased by the Department or another program) may be covered depending on the situation.

All technology should be itemized with a description and should include, when applicable, the model number, item number and manufacturer as well as any size or measurements that may be pertinent. Documentation should be uploaded to the client attachment portion of the LTSSMaryland system.

Options within the LTSS system include, but are not limited to:

- Audio Devices for the Blind
- Communication Devices

- Over the bed table
- Reacher
- Security Feature (lockbox/keypad)
- Software
- Water Temperature Gauge
- Other

Technology must:

- Prevent the participant's institutionalization;
- Ensure the participant's health, safety, and independence; and
- Specifically relate to ADLs or IADLs within the approved Plan of Service;

Some examples of technology:

- A specialized talking locked pill box prevents overdose and issues medication reminders during non-staffed hours. With this machine, staff/family is able to monitor medication and is able to set the machine to assist when supports are not available.
 - This reduces errors in medication and acts as a medication reminder otherwise performed by formal/informal supports.
- A lockbox or keypad on the front door enables a provider (e.g., personal assistant, home-delivered meals, etc.) to enter the residence without requiring someone to open the door.
 - This eliminates the need for formal/informal supports to be available at all times when services are being delivered or when a provider is going to arrive.

Supportive documentation or references to the interRAI assessment, or recommended Plan of Care completed by the Local Health Department, may be necessary. A reason or rationale why other DMS/DME is not being requested may be appropriate depending on the item.

Finally, multiple quotes/bids are required for any purchase exceeding \$1,000. There is a joint limit for this service of \$15,000 over three years when combined with accessibility adaptations.

An additional resource available to participants is the Maryland Department of Disabilities Technology Assistance Program (MDTAP). More information about how technology can support participants in their homes can be found at:

<http://www.mdod.maryland.gov/MTAP%20Home.aspx>

Nutritional supplements, gloves and wipes are not an allowable expenditure under technology and must be requested under DMS/DME.

Nurse Monitoring

Nurse monitoring is a service associated with personal assistance services. Only participants receiving personal assistance should receive nurse monitoring services. The Department recommends quarterly

visits; however, the frequency of visits should be based on recommendations from the Local Health Department nurse. Please note the rationale for the frequency in the comments section.

Nurse monitoring may be waived by the participant down to two visits per year. Monthly visits are not required by the program. If nurse monitoring is waived, the LHD will remain on the Plan of Service however contact should occur every six (6) months: one nurse monitoring visit and one annual STEPS comprehensive evaluation.

- Within the description of the service, please note the service was waived and upload the appropriate signed waiver form to the client attachment section of the LTSSMaryland system.
- Please note if the service is waived against the advice of the nurse monitor.

A participant residing in an assisted living facility should not have nurse monitoring. A participant living in the community but not receiving personal assistance services is also not eligible for nurse monitoring.

Any ancillary tasks related to instructions or delegation will be covered by the program, however nurse monitoring does not include skilled nursing tasks. If skilled nursing services are required, they must be provided by another program.

Only local health departments (LHDs) may provide nurse monitoring services under CFC. There will be no payment to other agencies for nursing supervision in the future. This provider requirement is being phased in through the summer of 2014. During this time, LHDs will be contacting each nursing agency to develop a transition plan. Current providers should continue to submit claims using the current code and rate until the LHD assumes the responsibility. After the LHD takes over the service, current providers can no longer bill for nursing supervision. Please see Appendix C for the role of the LHD in nurse monitoring for independent and agency personal assistance providers.

* Currently, some participants may continue to use an agency provider for these services during the transition to the Local Health Departments as the sole provider.

Nurse Supervision

Nurse supervision is a similar service to nurse monitoring however providers are agency-based and the service is not provided through a Local Health Department. Nurse supervision agencies will provide services to participants during the transition to a Local Health Department. This service will require an agency be selected from the provider list. The service may be waived and is not required in an Assisted Living Facility.

Supports planners should be in contact with their Local Health Departments about transition. When Local Health Departments are able to take responsibility, a Plan of Service modification will be required with the appropriate signatures.

Nurse supervision agencies may not bill skilled nursing tasks. If skilled nursing services are required, they must be provided by another program.

Nursing supervision DOES NOT use the ISAS call-in system for billing.

Agencies providing personal assistance services that are licensed as Residential Services Agencies must still comply with the licensure requirements in COMAR 10.07. Specifically, according to COMAR 10.07.05.12,

A registered nurse shall assess each new client who requires skilled services and assistance with the activities of daily living. The registered nurse shall also participate in developing the client's plan of care and in assigning appropriate personnel; determine whether the client requires the services of a certified nursing assistant, or whether services may be provided by an individual who is not certified; and participate in training and retraining the individuals who will provide the care, when indicated.

...an agency shall have a registered nurse to provide oversight for implementation of the care plan; delegation; supervision; and training.

All personal assistance provider agencies must continue to provide oversight and supervision by registered nurses as a part of the personal assistance service. The cost of nurse supervision is part of the administrative overhead built into the agency rate; there is no separate payment for this nurse. The time that a nurse spends on oversight and supervision is not billable and ISAS cannot be used to record the time of the nurse.

Personal Emergency Response Systems (PERS) Purchase and Monitoring

The initial purchase and installation of PERS is available to participants who live alone or may be alone for extended periods of time and do not have the reliable use of a cell phone.

A personal emergency response system is an electronic device or system which enables a participant to secure help in an emergency and may include, but is not limited to:

- A device connected to the participant's telephone or other device and programmed to signal, upon activation of a help button, a response center with properly trained staff on duty 24 hours a day, 7 days a week;
- A portable help button to allow for the participant's mobility; and
- A motion detector when necessary for the participant's safety.

CFC regulations limit the use of the PERS as follows in COMAR 10.09.84.23 Limitations.

A. Reimbursement for Personal Emergency Response System is limited to participants who:

(1) Live alone; or

(2) Have no regular caregiver for extended parts of the day and would otherwise require extensive routine supervision to ensure the participant's health and safety.

Extended parts of the day will be considered on a case by case basis during the POS review process. How the participant meets the criteria for this service should be noted in the details of the service on the POS.

This service is not available to MAPC participants or assisted living residents.

Supports Planning

Supports planning services (previously referred to as case management) is offered to all participants in the Community Options, CFC, ICS, and MAPC programs. Based on discussions with the participant, the supports planner should estimate the amount of time and frequency they will need to be involved with the participant. This will generally fluctuate throughout the year based on individual circumstances (e.g., transition, redetermination, provider changes, etc.).

Note that one monthly contact and one quarterly visit must be completed for all participants.

While participant needs may differ, the Department recommends:

- 20 hours per year for participants currently enrolled and living in an assisted living (80 units).
- 3 hours per month for currently enrolled participants (144 units).
- 6 hours per month for pending applicants (288 units).

If hours requested are expected to exceed those recommended above, a description of the need should be provided. If the supports planner consistently exceeds the number of hours recommended by the Department, a modification to the Plan of Service must be submitted with justification for the additional hours of service.

A participant may waive supports planning, however, it is important that individuals enrolled in the waiver, but who receive all of their services through the CFC program, must have at least one waiver service per month in order to maintain CFC eligibility.

If supports planning is waived, the supports planner will remain on the Plan of Service however contact will not be necessary except for program redetermination and eligibility checks.

- Within the description of the service, please note the service was waived and upload the appropriate signed waiver form to the client attachment section of the LTSSMaryland system.
- Please note if the service is waived against the advice of the supports planner.
- The supports planner must complete one activity monthly for each waiver participant (i.e., provide at least one Waiver Eligibility activity).
 - This is not required for CFC or MAPC participants.

Transition Services

Transition services are available for a participant when they are moving from an institution to the community or from an Assisted Living facility to a private residence. These services cover goods and services essential to transition. Transition services can be spent up to 60 days post transition.

Transition services may be used for participants discharging from a nursing facility to a home or residence or from an assisted living facility to a home or residence. Funds may not be used for participants who are moving from a nursing facility to an assisted living.

Transition services may include funds to/for:

- Obtain Housing (e.g., security deposit)
- Secure essential utilities (e.g., installation/setup fees)
- Basic furniture
- Small appliances or other approved appliances (e.g., a microwave)
- Essential personal or household items
 - Personal items such as soap, toilet paper, etc.
 - Household items such as sheets, dishes, towels, etc.
- Transition-related transportation

Transition services may not pay for:

- Rent, or
- Recreational items such as televisions, gaming systems, DVD players, cable television access, or other luxury items outside of the basic essentials.

Over the bed tables, reachers, ramps and other items that substitute for human assistance should be listed under the appropriate Technology or Environmental Adaptation sub-headings.

The Department's fiscal intermediary, PPL, will have further guidance on necessary information for this service.

This service is not available to MAPC participants.

Flexible Funds

A new service called flexible funds was offered through the MFP demonstration and administered by transitional supports planners to further address barriers to transition. This MFP supplemental service includes funds for groceries, transportation, clothing and other needed items that could not otherwise be funded by Medicaid. While the funds are designed to cover a wide array of goods and services needed at the time of transition, they have primarily been used to pay for groceries.

This service includes up to \$700 in flexible funds to pay for an initial supply of groceries when they transition, for transportation that will allow an individual to attend housing interviews and run errands related to the transition and to allow provision of needed goods or services that are not otherwise available.

This service is only available to MFP participants. If the request is for items that are allowable under transition funds (such as security deposit, utility hook-up, etc.), flex funds cannot be used unless transition funds have been exhausted. Flex funds must be expended within 60 days of transition.

Community Options Waiver and ICS Program Services

The following services are only offered to participants enrolled in the CO Waiver or ICS program. These participants are also eligible for certain CFC and State Plan services.

Assisted Living

This service is only available to those participants enrolled in the CO Waiver or ICS program.

Assisted living is a service offered instead of personal assistance. These two services may never occur on the same day and will rarely be on the same Plan of Service unless the participant is moving. The assisted living facility determines the level of services they will provide based on a medical assessment (level 2 or 3). The participant and the assisted living must agree whether the participant will attend Adult Medical Day Care as part of their Plan of Service.

- If Assisted Living with Adult Medical Day Care (AMDC) is selected, you must also add Medical Day Care in the Plan of Service and indicate the number of days AMDC will be attended.
 - The number of days attending Medical Day Care should equal the number of days of Assisted Living with AMDC.
 - For days in which the person will not attend Medical Day Care should be listed as Assisted Living without AMDC.
 - For instance, if the person lives in an assisted living seven days per week and attends Medical Day Care five days per week, the Plan of Service should list:
 - 5 days per week Assisted Living with AMDC,
 - 5 days per week Medical Day Care, and
 - 2 days per week Assisted Living without Adult Medical Day Care.
- Services offered outside of the bundled rate include allowable for participants residing in an assisted living are:
 - Medical Day Care
 - Behavioral Health Consultation
 - Senior Center Plus

Since assisted living facilities are paid a bundled rate, many services are *not offered* individually at the time the participant is living in the assisted living (they will be duplicative). The services not offered include:

- Nurse monitoring,
- Personal assistance services,
- Home-delivered meals,
- Environmental assessment and adaptations,
- Technology,
- PERS installation and/or monitoring,
- Dietitian and nutritionist services,
- Consumer Training, and
- Family Training.

Temporary Respite (Assisted Living and Nursing Facility)

Temporary respite may be provided by an assisted living facility and/or nursing facility (up to 14 days annually). Please follow these instructions when adding this service:

- Under the services drop down, select “Other.”
- Under Item Description state “Assisted Living – Respite, temporary stay.”
- Choose frequency type “monthly” and include number of days, 1 month and rate (\$72.05).
- Select the appropriate Medicaid Assisted Living Facility under the provider search.

- Under the description, add why the temporary move is planned as well as the dates in which the person will reside in that facility.

Note that these settings are only allowable for participants in the Community Options Waiver or ICS program. CFC and MAPC participants may not receive services in these settings.

Behavioral Health Consultation

This service is only available to those participants enrolled in the CO Waiver or ICS program.

These services are mainly offered when behavior is:

- Potentially dangerous to the participant's or another person's health and functioning; or
- Placing the participant at risk of institutionalization due to health and safety concerns.

The service includes a:

- Home visit by an individual qualified to render services to:
 - Evaluate a participant's behavior;
 - Assess the situation;
 - Determine the contributing factors; and
 - Recommend interventions and treatments;
- Written report with the results of the provider's assessment and recommendations to be reviewed by the participant, the participant's representative and family when applicable, and the participant's case manager and caregivers, which may include an assisted living provider; and
- Verbal review of the report with the participant, the participant's representative and family when applicable, and the participant's case manager and caregivers, which may include an assisted living provider, to discuss:
 - The report's findings and recommendations; and
 - A course of action, including any related needed medical interventions.

Dietitian and Nutritionist Services

This service is only available to those participants enrolled in the CO Waiver or ICS program.

The service includes nutrition care planning, nutrition assessment, and dietetic instruction. The service is approved when:

- The participant's medical condition requires the judgment, knowledge, and skills of a licensed nutritionist or licensed dietitian;
- Targeted to the individualized needs of the participant, rather than being of general interest;
- Sensitive to the educational background, culture, religion, eating habits and preferences, and general environment of the participant; and
- Specified in the participant's Plan of Service as necessary to:
 - Ensure the participant's health and safety; and

- Prevent the participant's institutionalization or hospitalization.

The service is not provided to participants residing in an assisted living facility.

Family Training

This service is only available to those participants enrolled in the CO Waiver or ICS program.

Family training may include:

- Instruction on treatment regimens and dementia;
- Use of equipment specified in the Plan of Service;
- Other issues; or
- Follow-up training as authorized.

This training may not be provided to participants residing in an assisted living facility.

Medical Day Care

This service is only available to those participants enrolled in the CO Waiver, ICS program, or the Medical Day Care (MDC) Waiver. It is not available to CFC only participants unless they are also enrolled in the MDC waiver.

If a CFC or MAPC participant wants to attend a Medical Day Care facility, they must apply to and enroll in the Medical Day Care Waiver separately. It is the supports planner's responsibility to ensure enrollment in the MDC waiver. The special program code will be displayed in the eligibility information section. If the person does not have an active/open MDC span and the person is not enrolled in CO or ICS, then the person is not eligible for the service. Placing MDC on the POS, even if approved, will not equate to eligibility for the participant without the proper application and special program codes.

This service may not overlap with personal assistance hours. If these services are combined, a description of days of the week with expected attendance should be included. The daily frequency chart may be helpful to easily display when each service is being provided. Additional information may be included in the comments.

Please see the guidance under assisted living for when a person will attend Medical Day Care while in the assisted living facility.

Senior Center Plus

This service is only available to those participants enrolled in the CO Waiver or ICS program.

This service may not overlap Medical Day Care on the same day. If these services are combined, a description of days of the week with expected attendance should be included.

There is a minimum age limit on this service that varies by provider. Supports planners should check with providers regarding their age requirements and availability prior to listing them on the participant's Plan of Service.

One day of attendance means at least 4 hours of service, not including transportation to and from the center. The services provided include a program of structured group recreational activities, supervised care, assistance with activities of daily living and instrumental activities of daily living, and enhanced socialization provided in an out-of-home, outpatient setting. Social and recreational activities designed for elderly, disabled individuals, as well as one nutritious meal shall be available within the center's confines.

As this service includes the provision of a meal, home-delivered meals may not be provided for the meal during which the person is at the Senior Center Plus program. Any co-occurrence of home-delivered meals and Senior Center Plus should be explained in comments or reflected in the daily service chart to assure that there is no duplication of services.

Please note that this service is not associated with Senior Care or a regular Senior Center. This is a specific Medicaid service paid for under the waiver. Information regarding similar programs may be listed under the “other” service and should note days/times the person regularly attends.

State Plan and Other Services

Each service listed under this section has its own eligibility criteria and the appropriate program within the Department should be contacted. Signatures for these services are not required because they are not covered under the CO, ICS, CFC or MAPC programs. These are for information to ensure coordination of services and to estimate cost neutrality when applicable.

The Department’s Plan of Service Unit is not responsible for the approval or denial of any of the services listed in this section.

Dentist Visit

This is a service that may be offered through a participant’s managed care organizations (if applicable) and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Dialysis

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Disposable Medical Supplies and Durable Medical Equipment (DMS/DME)

These are State Plan services that are offered by a different program under the Department’s Division of Community Support Services (DMS/DME unit). Please review the list of DMS/DME allowable at:

<https://mmcp.dhmdh.maryland.gov/communitysupport/SitePages/approvedlist.aspx>

While these items should be included in the Plan of Service, approval of an item is contingent on the Medicaid’s DMS/DME unit. Certain limitations may exist based on the approved list of covered items. Additional items will not be covered in excess of the DMS/DME approval.

Since this service is not approved by the CO, ICS or CFC programs, a provider name is not required on the Plan of Service however any known costs for items should be included (and the date of purchase). These costs do count towards cost neutrality for waiver participants.

If an item is determined by the DMS/DME unit to be not medically necessary, or not coverable due to service limitations, the item will not be covered under the CFC program. As part of the POS Unit review, staff will review denials made by the DMS/DME unit based on medical necessity.

The Department's Plan of Service Unit will review items not covered under the formulary separately.

Mental Health Services

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known. For additional resources, please contact the local Core Service Agency.

Occupational Therapy

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known. This service is covered only for children under the State Plan and through REM. Certain exceptions apply for those participants in a hospital or in the Home Health program.

Other

Any service not covered by the waiver, ICS, CFC or MAPC may be listed here. Provider name, rate and frequency may be left blank. This is mainly used for informational purposes but should include pertinent services that will help encompass the entirety of services being provided to the participant.

Please see the Temporary Respite section for instructions on how to add this particular service in the "other" category.

Physical Therapy

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Physician Visit

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Skilled Nursing

This is a State Plan service available for certain participants and should include the frequency in which it will occur. Rate and provider may be left blank unless otherwise known. Since this is a high cost service, please include a description of the service as it may affect a waiver participant's cost neutrality.

This is a limited benefit offered under Private Duty Nursing for children under EPSDT and for adults in REM or Model Waiver. It is also offered through the Home Health benefit, which is a short term, post-acute service. This is not a covered service under the waiver, CFC, MAPC and ICS program.

Speech Therapy

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known. This service is covered only for children under the State Plan and through REM. Certain exceptions apply for those participants in a hospital or in the Home Health program.

Substance Abuse Services

This is a State Plan service and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Transportation

Non-emergency medical transportation is a State Plan service that covers transportation to approved medical services and should include a general estimate of the frequency in which it will occur. Rate and provider may be left blank unless otherwise known.

Medicaid does not pay for transportation to non-medical, recreational activities.

Signatures

The participant and all providers in the Plan of Service must sign the Plan of Service according to the Federal CFC regulation. This confirms the agreement that services will be provided in the projected frequencies. These signatures should be captured on paper and kept on file by the supports planning agency. Audits may be conducted to ensure signatures have actually been captured.

At a minimum, the following signatures are required by the Department when approving a provisional Plan of Service:

- Participant
- Supports Planner
- LHD Nurse Monitor

At a minimum, the following signatures are required by the Department when approving an initial or annual Plan of Service:

- Participant
- Supports Planner
- Personal Assistance provider(s)
- LHD Nurse Monitor

Please note the following:

- The participant's signature on the plan of service indicates their agreement with the plan. If they don't agree, they should not sign.
- While not required at the time of approval, it is highly recommended that the signature of the emergency backup provider and any agency-based nurse monitor are included in the Plan of Service.

- If signature of personal assistance provider has not yet been collected, e-mail verification between the Department and the supports planner may suffice that contact and agreement has been made with the personal assistant provider. However, signature must be gathered as soon as possible.
- If nurse monitoring will be conducted by the Local Health Department, a signature will be required to ensure readiness at the time of the effective date.
- Signatures for State Plan services are not required.
- The signature for Public Partnerships LLC (PPL, Inc.) is not required.

Participant Signature

The participant's signature on the plan of service indicates their agreement with the plan. If they don't agree, they should not sign. DO NOT coerce a participant into signing a plan of service with which they don't agree. Forcing a participant to sign a plan that they do not accept denies them their appeal rights. The Department cannot process appeals for approved plans of service as the Department did not deny anything.

If a participant does not agree with a plan that is within the flexible budget, work to develop a plan of service that they are willing to sign with services that are acceptable to the participant. Submit the acceptable POS with the participant's signature.

If the plan that is acceptable to the participant is denied by the Department, then appeal rights apply. If the participant appeals the Department's decision timely, the current level of service is maintained until the appeal process is complete.

Refusing to sign any plan of service could result in a technical denial.

Review

This section should be reviewed prior to submission. The section auto-populates certain answers but requires the supports planner, or their lead, to check to ensure that the plan of service meets the participant's health and safety needs.

If the supports planner does not believe the Plan of Service meets their needs, however the participant requests submission, the Department will review and contact both groups to discuss remediation.

Once the supports planner submits a Plan of Service, the Lead at that supports planning agency should review. This review process may be developed by each agency, however, following the guidelines in the remainder of this document will prove beneficial in getting plans of service approved more timely. If questions remain, the lead/supervisor may use the "request clarification" button to enable editing by the original supports planner. Otherwise, they may submit to the Department.

Plan of Service Unit Staff

Plan of Service staff will receive an alert in the LTSSMaryland system when a Plan of Service is submitted. When an alert is received, the participant record will also be listed in the staff's My List.

Pending Applicants

There is a two-step process for completing and approving plans of service for pending applicants:

- Reviewing and approving a provisional Plan of Service which includes services but may not list all providers.
- Reviewing and approving the initial Plan of Service.

Enrolled Participants


A participant's eligibility for each program, as well as services in the Plan of Service, is redetermined every 12 months. The annual redetermination process requires a Plan of Service that includes applicable waiver, State Plan, community and other services needed for the participant to remain in the community. The same criteria reviewed for pending applicants is also reviewed. In addition, information from the previous approved Plan of Service should be reviewed for consistency and any changes in service levels should be noted.

Review Steps

Initially, staff should review the interRAI-Home Care assessment, recommended plan of care and the Plan of Service for completion. These can be found under the client's Program section of the LTSSMaryland system, by clicking on "Assessment and Plan of Care" and the "Plan of Service" tabs.

Both provisional and initial plans of service are reviewed to assure the Plan of Service includes appropriate waiver, State Plan, community and other services developed jointly with the participant and the supports planner to meet the participant's needs to reside safely in the community. The following information is reviewed:

- AERS assessment.
- AERS recommended plan of care.
- Level of care (LOC) required for the program is met.
- Services provided by other Medicaid programs.
- Any denial of medical necessity for a particular item/service (e.g., DMS/DME)
- Services requested with justification.
- Both Medicaid and non-Medicaid services meet health and safety requirements for the participant.
- Emergency backup section is complete.
- Signatures for the participant and all required providers are captured.
- Exceptions form (if applicable) rationale and documentation.
- Cost effectiveness and appropriateness of the Plan of Service.
 - Cost neutrality figures are not exceeded; the following symbols will appear when cost

neutrality is not met:  Over 100% or  Over 125% .

Within the interRAI assessment, certain fields may be useful when reviewing the need for hours of service, items that substitute for human assistance and other services within the Plan of Service. These include:

- From the interRAI
 - Section N. Treatments and Procedures (Formal Care)
 - Section P. Informal Supports
- From the interRAI Results Summary
 - Social Functioning, Social Support and Home Situation
 - Physical Functioning
 - Falls Risk

Commonly Requested Documents

To help assist the Department in making a decision, there are several common documents that may need to be submitted in order to approve a Plan of Service. These documents may include:

- Prescriptions,
- Discharge papers,
- Medical and/or environmental assessments,
- Clinical notes,
- Staffing patterns,
- Denials from other insurer/s, and
- Pictures of the home/space.

Department Plan of Service Decisions

The Department may not have enough information to make a determination of the Plan of Service without additional documentation. The POS Unit Staff may contact the supports planner or participant *via* phone or email or may “request clarification” within the LTSSMaryland system. By doing so, a comment will be sent to the supports planner to answer additional questions or provide more documentation. This will also allow the supports planner to edit the Plan of Service further prior to re-submitting.

After working with the supports planner without resolving outstanding issues, the Department may deny a Plan of Service. The following are reasons in which the Department will deny a Plan of Service:

- Does not meet health and safety.
- Exceeds cost neutrality or the recommended flexible budget without sufficient justification.

Appeal rights are given to all participants if their Plan of Service is denied. All denials may be appealed within 10 days in order for current service levels to remain in place; however appeals will be accepted until 90 days after denial.

Appendix A – Coverage Groups

Quick Reference Guide to Medical Care Program Coverage Groups and HealthChoice Eligibility

Children

- *P06 Newborns of Eligible Mothers and children under 1 year old, up to 199% FPL
- *P07 Children 1 up to 6 years old, 143% FPL, and 6 up to 19 years old, 138% FPL
- *F98 Children 19 & 20 years old, up to 123% FPL
- *P13 Title XXI MCHP, Child 1 up to 19 years old, up to 189% FPL
- *P14 Title XXI MCHP, Child under 19 years old, 190 – 211% FPL

Maryland Children's Health Program (MCHP) Premium

- *D02 MCHP Premium, 212 - 264% FPL
- *D04 MCHP Premium, 265 - 322% FPL

Parents

- *F02 Post TCA Extension (also includes children)
- *F05 FAC – Parents/Primary Caretakers, up to 123% FPL
- *A03 New, Parents and Caretaker Relatives (includes children 19 & 20 years old), 124–138% FPL

Pregnant Women

- *P02 Pregnant Women up to 189% FPL
- *P11 Pregnant Women 190 – 264% FPL
- #P10 Family Planning Program services only

Childless Adults

- *A01 Childless Adults up to 65, up to 138% FPL, Former PAC enrollees
- *A02 Childless Adults (including disabled > 77% FPL (103% FBR)) up to 65, up to 138% FPL
- *A04 Disabled Childless Adults, up to 77% FPL (103% FBR)

Foster Care & Subsidized Adoptions

- *†E01 IV-E or SSI, Foster Care or Subsidized Adoptions
- *†E02 Non-IV-e, Foster Care or Special Needs Subsidized Adoption & Subsidized Guardianship
- †E03 State Funded Foster Care
- †E04 State Funded Subsidized Adoptions & Subsidized Guardianship
- *E05 Former Foster Care up to 26 years old

Refugees

- *†G01 Refugee Cash Assistance (RCA)
- *†G02 Post RCA Extension – Earnings
- *†G98 Refugee Medical Assistance
- †G99 Refugee Medical Assistance, Spenddown

Home & Community Based Waivers & PACE

- *†H01 HCB Waiver and PACE

Aged, Blind or Disabled (ABD)

- *†S01 Public Assistance to Adults (PAA)
- *†S02 SSI Recipients
- †□S03 Qualified Medicare Beneficiaries(QMB)
- *†S04 Pickle Amendment
- *†S05 Section 5103
- †□S06 Qualified Disabled Working Individuals(QDWI)
- †□S07 Specified Low Income Medicare Beneficiaries I (SLMB I)
- #S13 Not in Use (ACE)

- #S13D Employed Individuals With Disabilities (EID)
- #S14 Qualifying Individuals (QI) [also called SLMB II]
- #S16 Increased Community Services Program (ICS)
- *†S98 ABD – Medically Needy
- †S99 ABD – Medically Needy With Spenddown

Families & Children Long Term Care

- †T01 TCA Adult or Child in LTC
- †T02 FAC Child in LTC
- †T03 MCHP Child Under 1 in LTC (P06 Standards)
- †T04 MCHP Child Under 6 in LTC (P07 Standards)
- †T05 MCHP Child Under 19 in LTC (P07 Standards)
- †T99 FAC Child in LTC With Spenddown

Aged, Blind or Disabled Long Term Care

- †L01 SSI Recipient in LTC
- †L98 ABD Long Term Care
- †L99 ABD Long Term Care With Spenddown

Women's Breast and Cervical Cancer Health Program

- #W01 WBCCHP (No new applications accepted after 12/31/13; Grandfathered program)

Aliens

- †X02 Non-MAGI Undocumented or Ineligible Aliens (Emergency medical services only)
- X03 MAGI Undocumented or Ineligible Aliens (Emergency medical services only)

Meaning of symbols n front of coverage groups

- * **HealthChoice Eligible unless:**
 - √ On Medicare
 - √ Living in an Institution
 - √ Living Out of State
 - √ Waiver Code of MOD or MWD for Model Waiver
- # **On MMIS Only**
- † **Eligibility Determined in CARES**
- **Medicare Savings Program**

No shading – financially eligible for MAPC/CFC

Dark Grey – Not eligible for MAPC/CFC

Appendix B – Special Program Codes

Program	Special Program Code	Key
Model Waiver	MOD	Model Waiver-Deinstitutionalized
	MWD	Model Waiver-Diverted
Autism Waiver	AUT	Autizm Waiver
Community Pathways (Waiver)	MRW	Intellectual Disability, deinstitutionalized
	DRW	Intellectual Disability, diverted
	NRX	Developmentally disabled, diverted
	DRM	MFP - Intellectual Disability, diverted
	NRM	MFP - Developmentally disabled, deinstitutionalized
New Directions (Waiver)	NRW	Developmentally disabled, deinstitutionalized
	MRM	MFP Intellectual Disability, deinstitutionalized
Traumatic Brain Injury Waiver	TBW	Traumatic Brain Injury Waiver
	TBM	MFP-Traumatic Brain Injury Waiver
Living at Home Waiver	ACD	Living at Home-Deinstitutionalized
No Longer in Use	ACI	Living at Home-Diverted
	ACM	MFP-Living at Home
Residential Treatment Center Waiver	RTC	RTC Waiver
Community Options Waiver	OAA	Community Options Waiver-Assisted Living
	OAH	Community Options Waiver-Private residence
	OHM	MFP - Community Options Waiver-Private residence
	OAM	MFP - Community Options Waiver-Assisted Living
Rare and Expensive Medicine	APD	Asymptomatic Pediatric Disease
	BLD	Blood Disease
	CON	Congenital Anomalies
	DEG	Degenerative Disease
	IID	Infant with Inconclusive Disease
	MET	Metabolic
	PSA	Pediatric Symptomatic Disease
	VDP	Ventilator Dependent Person
	OTH	Other
Hospice	HOS	Hospice
Medical Day Care	MDC	Medical Day Care
Increased Community Services	ICS	Increased Community Services
	ICM	MFP-Increased Community Services

In order for waiver claims to pay, the appropriate special program code must be listed on screen 8 of the participant subsystem in MMIS. DEWS updates the Special Program Code upon enrollment and disenrollment.

There is no Special Program Code for CFC or MAPC because they are State Plan Services

Appendix C – Nurse Monitoring

Nurse Monitoring

